

## West Nile Virus Investigation Form



**LHD ID#** \_\_\_\_\_

### **Patient Information**

---

Name \_\_\_\_\_  
LAST FIRST MIDDLE

Address \_\_\_\_\_  
Street address City State Zip

Phone number (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M F  
mm dd yy

Race: White Black Asian/Pacific Islander Native American

Ethnicity: Hispanic Non-Hispanic

Contact name (if patient is unable to answer questions) \_\_\_\_\_

### **Clinical Information – PHYSICIAN TO FILL OUT (check yes for all that apply)**

---

Patient symptomatic? Yes No

SYMPTOM ONSET DATE: \_\_\_\_\_

☐ **WEST NILE FEVER:** Febrile illness with sudden onset accompanied by malaise, vomiting, myalgia, anorexia, eye pain, rash, nausea, headache, lymphadenopathy.

☐ **NEUROINVASIVE:**

☐ **Meningitis:** Sudden onset of febrile illness with signs and symptoms of meningeal involvement, possible rash, transient paresis and encephalitic manifestations may occur. Paralysis is unusual.

☐ **Encephalitis:** Febrile headache, acute onset, fever, disorientation.

☐ **Acute Flaccid Paralysis:** Acute onset of asymmetric weakness and areflexia but no sensory abnormalities. Possible involvement of spinal anterior horn cells, resulting in a poliomyelitis-like syndrome.

☐ **ASYMPTOMATIC BLOOD DONOR**

**Past or Present Medical History (these can affect interpretation of lab results)**

---

Past vaccination or past exposure/infection of any of the following (circle all that apply):

*St. Louis encephalitis*

*Powassan virus*

*Japanese encephalitis*

*Tick-borne encephalitis complex viruses*

*Dengue virus*

*Murray Valley encephalitis*

*Yellow Fever*

**Hospitalized?**                      **YES**                      **NO**

---

Date admitted: \_\_\_\_\_ Date discharged: \_\_\_\_\_

Hospital: \_\_\_\_\_

Did patient die?                      **YES**                      **NO**

If yes, date expired: \_\_\_\_\_

**Other modes of transmission (Check if applicable)**

☐

Transfusion in 20 days prior to onset of symptoms?

Institution's name: \_\_\_\_\_

Date of transfusion: \_\_\_\_\_

**NOTE:** Remind reporting transfusion facility to notify blood supplier of potential transfusion transmission.

☐

Transplant within 4 weeks prior to onset of symptoms?

Institution's name: \_\_\_\_\_

Date of transplant: \_\_\_\_\_

**NOTE:** Remind reporting transplant facility to notify organ supplier of potential transplant transmission.

☐

Patient pregnant?                      Due date: \_\_\_\_\_

☐

Patient breastfeeding or being breastfed?

Duration: \_\_\_\_\_

☐

Patient have workplace exposure (needle stick, laceration, etc.)

☐

Donate blood/organs?

Institution's name: \_\_\_\_\_

Date of donation: \_\_\_\_\_

**NOTE:** Report information to blood or tissue supplier immediately

**Travel:**

Has patient traveled in the 2 weeks prior to onset of symptoms?    Yes    No

If yes, where? \_\_\_\_\_

## Laboratory

---

Either attach the laboratory report or completely fill out the following chart:

Name of laboratory performing tests: \_\_\_\_\_

Specimen source:	SERUM	CSF	Test date
IgM serology (EIA/ELISA)			
Numerical Value:	_____	_____	_____
IgM serology (EIA/ELISA)			
Numerical Value:	_____	_____	_____

Specimen source:	SERUM	CSF	Test date
*Total IgG serology (EIA/ELISA)			
Numerical Value:	_____	_____	_____
*Total IgG serology (EIA/ELISA)			
Numerical Value:	_____	_____	_____

*\*IgM positivity is suggestive of acute infection. IgG positivity alone does not suffice for determining diagnosis. IgG results can cross-react with the other flaviviruses listed above.*

### CSF Results:

Date:_____	Culture:_____
Protein:_____	Glucose:_____
WBC:_____	RBC:_____

**Patient's physician and phone number:**

**Reporting Date:**

**Please Fax to Local Health Department Number**

**LHD ID#**\_\_\_\_\_

**Mosquito Abatement Information:**

Home address:\_\_\_\_\_

Standing water at this location?	Yes	No
----------------------------------	-----	----

Mosquitoes Observed?	Yes	No
----------------------	-----	----

If yes, time observed:\_\_\_\_\_

Work address:\_\_\_\_\_

Standing water at this location?	Yes	No
----------------------------------	-----	----

Mosquitoes Observed?	Yes	No
----------------------	-----	----

If yes, time observed:\_\_\_\_\_

Recreational Places:\_\_\_\_\_

Standing water at these locations?	Yes	No
------------------------------------	-----	----

Mosquitoes Observed?	Yes	No
----------------------	-----	----

If yes, time observed:\_\_\_\_\_

**Please fax this form to your local Mosquito Abatement District**

November 27, 2006